

Professional Licensing Agency
402 West Washington Street
Room W072
Indianapolis, Indiana 46204



Michael R. Pence
Governor of Indiana
Nicholas W. Rhoad
PLA Executive Director

This form can **ONLY** be used if your license is expired. If you hold an active license you must renew online here: <https://mylicense.in.gov/EGov/Login.aspx>

Expired Nurse Midwife Renewal Form

Your license is expired. You may renew your license online at www.pla.in.gov for about 18 months after the expiration. To renew by mail, please print and complete this form in its entirety and submit it with the renewal fee of \$100.00 to the office address shown in the above right corner. If you answer 'Yes' to any question below send a detailed statement regarding the response with this form and fee.

LICENSEE INFORMATION: Update address, if needed, and provide a current phone number and email address			
Enter Licensee Name	Enter License Number	Enter Expiration Date	Renewal Fee \$100.00
Street Address			
City	State	Zip Code	
Phone Number	Email Address		

QUESTIONS		
1. Since you last renewed, has any health professional license, certificate, registration or permit you hold or have held been disciplined or are formal charges pending?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. Since you last renewed, have you been denied a license, certificate, registration, or permit in any state?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3. Since you last renewed, and except for minor violations of traffic laws resulting in fines and arrests or convictions that have been expunged by a court, have you been arrested, entered into a diversion agreement, been convicted of, pled guilty to, or pled nolo contendere to any offense, misdemeanor, or felony in any state?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4. Since you last renewed have you had a malpractice judgment against you or settled a malpractice action?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5. Have you been reprimanded, disciplined, demoted or terminated in the scope of your practice or as another health care professional?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
6. Since you last renewed have you been excluded from being a Medicare or Medicaid provider?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

LICENSEE AFFIRMATION	
By signing below, I hereby attest that the information listed on this renewal application is true, complete and correct.	
Signature of Licensee	Date (month, day, year)

Visit us on the web at www.pla.in.gov for additional information regarding your licensure, or email the Board at pla2@pla.in.gov.

FOR OFFICE USE ONLY		
Renewal Fee	Receipt No.	Date